

STATES *of* HEALTH

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Medicare HMO Marketing and Information: Keeping the Focus on What Consumers Need

*A*cross the country, Medicare beneficiaries face complicated choices about health insurance and HMOs, but too often they lack the information they need to make good decisions. Instead, they rely on marketing information that is frequently inadequate, sometimes downright misleading. This issue of States of Health looks at efforts to improve the ways that HMOs market their Medicare plans and assesses whether “choice” really benefits beneficiaries.

Belle Likover recently received a phone call from the extremely distraught daughter of a Medicare beneficiary. The caller's 81-year-old mother had just signed up with an HMO, but now she needed to leave the health plan.

It's a story Likover has heard before as chair of the Cleveland-based Coalition to Monitor Medicare Managed Care, a project of the Western Reserve Area Agency on Aging. The coalition is working to protect elderly and disabled Medicare beneficiaries who now face increasingly complex choices about types of Medicare plans.

“The sales agent kept telling her, ‘You'll save money,’ ” recalls Likover. “The woman kept saying she wanted to check with her daughter first, that

the most important thing to her was that she be able to keep seeing her doctor.” Unable to say “No,” she finally yielded to the agent's persistence and signed up with the HMO.

Not until the doctor's office called to cancel an upcoming appointment did the elderly woman begin to realize what she had done. Her doctor was not part of the HMO.

Likover, who at the age of 79 is a longtime Medicare beneficiary herself, says that such marketing abuses may not be that commonplace anymore. Indeed, despite continuing reports of problems,¹ some Medicare experts say that HMO marketing has gotten better.

In Ohio, Likover adds, local managed care plans are trying to improve their sales materials and practices. “But you still get HMO reps that are too gung ho, that push a little too hard,” she comments. “And the woman whose daughter called was a little cognitively impaired, as many people are at that age. So she was confused, and she got talked into it.”

The Medicare Mantra: Choice

This fall, the federal Health Care Finance Administration (HCFA) begins implementation of its Medicare + Choice initiative, a new spectrum of private-sector Medicare plans authorized by the 1997 Balanced Budget Act. Yet with over 15 percent of Medicare beneficiaries enrolled in HMOs—a share projected to reach 20 percent next year—many beneficiaries still can't differentiate HMOs from traditional fee-for-service Medicare.²

Meanwhile, Medicare advocates throughout the country are working to prepare for an onslaught of Medicare + Choice acronyms: PSOs (provider-sponsored organizations), PPOs (preferred provider organizations), POS (point-of-service) plans, PFFS (private-fee-for-service) plans, and MSAs (Medicare savings accounts).³

Nor will this alphabet soup be the last word on “choice” for Medicare. Congress plans to debate the “premium support” approach, despite the refusal of the Bipartisan Commission on the Reform of Medicare to endorse it. The commission's chair, Louisiana Democratic Senator John Breaux, has resurrected the proposal to essentially hand every Medicare beneficiary a federal voucher to buy coverage. Clearly, Congress has not exhausted its appetite for creating private-sector Medicare “choices.”

Professor Shoshanna Sofaer, of the

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STATES of HEALTH

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Kate Villers
PRESIDENT

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City University of New York's Baruch College, studies consumer decision-making about health care. Currently chairing a working group on Medicare sponsored by the Century Foundation, Sofaer says she is no "HMO-basher" and still believes managed care may be better for the elderly, but she is skeptical about the rush to create "choices."

"All these options under Medicare + Choice are going to totally overwhelm people and confuse them," says Sofaer. "It's too many choices. The important question is, 'Choice of what?' We've made choice into this mantra, but what does it mean? What kind of choice is a good choice? What kind of choice is private fee-for-service for me if I'm a low-income woman who's chronically ill and needs constant coordination of care?"

There's another fundamental question, notes Community Catalyst Executive Director Kate Villers. "The obsession with choice has sidelined discussion of an even more basic ques-

tion: Is the proliferation of multiple choice options in Medicare really the direction we should be moving in? I would say it is *not* the right approach."

Apparently, though, no one in Washington wants to ask that question. Meanwhile, the congressional rush to impose market-based competition on Medicare presumes that a "buyer beware" approach is enough to ensure that Medicare beneficiaries make good decisions.

It's clearly not that simple.

"Some in Congress may think that people inherently know what form of health insurance is right for them," says Steve Edelstein, of the New York-based Center for Medicare Education. "I don't think that people do, especially given the complexities in how these plans will operate. For choice to work, you need an educated consumer. Whether people in Congress realize how you get to that, what goes into making that happen, is unclear."

HCFA's Education Campaign

The Medicare + Choice education campaign has not been well received. Congress raised \$95 million in education funding from HMO fees, and HCFA spent nearly all of it on a telephone hotline and national distribution of "Medicare + You," a detailed 36-page handbook.

The handbook has not drawn rave reviews. Some say it's too dense; the information, too complicated. A waste of money, others say. Stories abound of seniors who threw the booklet out with their junk mail.

Most observers agree that the Health Care Finance Administration can't possibly do this job. It simply doesn't have the expertise, says Patricia Neuman, director of the Kaiser Family Foundation's Medicare Project. "Competing with marketing and advertising

materials is hard," she says. "It's hard for consumer groups, and it's hard for HCFA, neither of which are in the business of jazzy marketing. That's one of the structural problems inherent in making traditional Medicare compete with private-sector managed care."

Joyce Dubow, of AARP's Public Policy Institute, doesn't really fault HCFA, either.

"HCFA's trying, and they're learning," Dubow explains. "But it's very costly to do this, and to do it so that you really engage people. We know that simpler is better and that you ought to use a 'layered approach' in educating people, but for a host of reasons, HCFA can't always act solely from that set of imperatives. They feel obligated to always be legally correct. There's no one answer for everyone, we're trying to reach such diverse populations. So you wind up with this handbook, and simple, it ain't."

Medicare Rights Center Assistant Director Joe Baker agrees. "When it comes to HCFA developing its educational materials, they've got more constituencies than just consumers," says Baker. "If the HMOs don't like what they see, HCFA's going to get plenty of flack. That's why there's an important role to play for independent non-profit agencies, like ours, that are only focused on consumer needs and rights."

Much of the work of preparing beneficiaries for Medicare changes has fallen to local groups. These include state Area Agencies on Aging, the State Health Insurance Programs (sometimes also known as Health Insurance Counseling and Advocacy Programs), and other beneficiary advocates, all of whom this year received just \$7 million in additional federal funding for Medicare + Choice education and outreach. They're work-

ing feverishly to find strategies that can help seniors and the disabled make good Medicare decisions.

In some communities, local Medicare HMOs are also working with them. Cleveland's ten HMO plans have actively consulted with the Coalition to Monitor Medicare Managed Care to improve their marketing operations. Despite that, Likover says, "there are still going to be people who sign up and just don't know what they're doing."

How HMOs Market "Choice" to Medicare Beneficiaries

Likover's story about the 81-year-old Cleveland woman is not unique, unfortunately. Every Medicare counselor, ombudsman, or educator who spoke with *States of Health* had a similar account to tell:

- An Ohio couple, ages 87 and 89, got an invitation on their doctor's letterhead to learn about the area's newest health plan. They arrived at the doctor's office to find a marketing agent with a sales pitch they felt obliged to accept, out of loyalty to their physician.
- Pennsylvania beneficiaries enrolled "on the spot" with an HMO that was handing out small gifts at the mall or offering prospective members a free meal at Denny's.
- A New York City man could not speak English but signed up with an HMO that sent its marketing agent to his ESL class.
- In Atlanta, a woman with early Alzheimer's agreed to sign something that, the marketing agent told her, "just shows we've talked." When Medicare denied payment for her CAT scan, it turned out that she had joined an HMO her doctors didn't belong to and her care had not been authorized.

Medicare counselors around the country are busy with cases like these, getting clients out of managed care plans they have mistakenly joined.

While some policy experts say that Medicare HMO marketing has become more responsible since the mid-'90s, problems still exist, according to a recent project funded by the Retirement Research Foundation and conducted by Community Catalyst and the Gerontology Institute of the University of Massachusetts, Boston.

Collaborating with four consumer health coalitions—the Campaign for Better Health Care in Illinois, Health Care For All in Massachusetts, the Oregon Health Action Campaign, and the Louisiana Health Care Campaign—researchers Karen Quigley and Nancy Turnbull studied how HMOs advertise and promote their Medicare plans. With Community Catalyst assistance, the coalitions recruited and trained consumer volunteers to monitor HMO marketing practices. The monitors posed as potential enrollees, conducted telephone interviews, attended marketing meetings, and hosted home visits by HMO marketing representatives. The project also reviewed brochures and other printed marketing materials.

The researchers and monitors reported little evidence of pressure sales or illegal inducements to enroll, but they did find that many HMOs provided incomplete or misleading information. In fact, over 40 percent of the time, the health plans failed to provide important information needed to decide whether to join an HMO.

Turnbull and Quigley identified 16 information items that are critical for decision-making. Across all four markets, HMOs consistently failed to disclose such information and failed to market fairly to all eligible comers. For example, patient rights information about grievance and appeal procedures was often left out. Nor were consumers adequately advised that joining an

HMO could make it difficult for them to purchase Medigap coverage again. Moreover, marketing often seemed to target "healthy seniors." Glossy brochures featured barely wrinkled retired golfers; meetings took place in buildings inaccessible to the disabled; and few HMOs had translated materials for those speaking limited English.

Studies by the Kaiser Family Foundation, the federal General Accounting Office, and others have identified similar problems. But the Community Catalyst/Gerontology Institute study was unique in using consumers to monitor how HMOs sell their Medicare plans.

The Special Demographics of the Medicare Population

Such on-the-ground, data about what's happening in the field may be essential to protecting seniors from misinformation and poor decisions—particularly as their options multiply. It's especially crucial, Community Catalyst Policy Director Michael Miller notes, because HMO marketing activities are but one piece of a complicated puzzle.

Another piece is the special character of the Medicare population. "The senior who's considering a Medicare HMO today is doing it on his or her own," Miller explains. "They don't have the help of an employee benefits person at their workplace or union. That means the Medicare population is especially dependent on HMO marketing information—because in too many cases, nobody is screening that information for them."

Other factors heighten the vulnerability of Medicare beneficiaries. Nearly one-quarter have cognitive impairments and memory problems. General literacy and, particularly, health literacy, tend to be low: some

beneficiaries don't speak or read English well and need translated materials, which are scarce. Access to information is limited for those whose chronic illness or disability leaves them homebound or isolated.

For many beneficiaries, stability may be Medicare's one characteristic of utmost importance. "It may be that the best analysis of traditional Medicare's selling point came from one guy at a focus group we ran," Kaiser's Neuman notes. "Asked 'What do you like best about Medicare?' he said, 'That it's there.'"

"Being there" seems a modest requirement—yet more than 400,000 Medicare beneficiaries lost coverage last year because they enrolled in HMOs that later withdrew from the market. This year 30,000 Seattle beneficiaries lost coverage and now, says Pam Piering, of the county's office of aging and disability services, "seniors are suddenly waking up to the realities of these private market forces, and realizing 'Hey, my HMO might disappear on me.'"

It's a rude awakening for a generation with little experience of managed care and that assumes, as Piering explains, that "Medicare coverage is Medicare coverage. You sign up for it when you're 65, and you have it until you die."

Finally, there's another special characteristic of the Medicare population: its need for health care. More often than younger people, Medicare beneficiaries get sick, they are frail, and their illnesses may be chronic and very complex. For them, the stakes are higher and, says Neuman, "the risks of making a bad choice in selecting a health plan are terribly serious."

Not only do Medicare beneficiaries have special needs; what they need to learn is not simple, either. Every

Medicare expert has an anecdote about an audience that should—but didn't—understand managed care. Medicare expert Vicky Gottlich, of the National Center for Senior Citizen Legal Services, is part of a task force advising HCFA on standardizing benefits information. Recently, she led a national training session for volunteer advocates and found that even this audience was confused about the difference between Medicare HMOs and the frequent pairing of traditional fee-for-service Medicare and supplementary Medigap coverage.

"When I asked how many in the audience had Medicare managed care plans, virtually everyone raised their hands," Gottlich recalls. Only later did she find out that most had been mistaken: they had Medicare supplemental plans, not HMOs.

Who's Doing the Educating?

Medicare beneficiaries need good information to choose the health plan that best meets their needs, but who does most of that education? Medicare researcher Judith Hibbard and others say it's the managed care companies themselves: most Medicare beneficiaries get their information from HMO ads and marketing campaigns.⁴ Obviously, the primary purpose of marketing materials is to sell; they are not designed to protect the consumer's interest.

Competing with marketing materials isn't easy. Some groups, like the Center for Health Care Rights in California and the Medicare Rights Center in New York, have relatively sophisticated expertise in this area. But cash-rich HMO marketing machines vastly outgun most of the Area Agencies on Aging, State Health Insurance Programs, and other local groups that comprise the public infrastructure for

Medicare education.

The Medicare Rights Center has created one of the most popular Medicare + Choice educational tools, the "Medicare Options Traffic Light." This easy-to-read chart compares traditional Medicare with existing HMOs and the new Medicare + Choice private health plans. The chart uses six criteria to help consumers rate a plan's ability to meet their needs, including whether a member can: choose any doctor, see specialists, or afford the plan on a fixed budget. Based on a green (go), yellow (caution) or red (stop) light on the chart, consumers concerned about a particular feature can find out: if a plan meets their needs, if they should be careful and ask more questions, or if a plan won't meet their needs.

Medicare Rights Center Associate Director Joe Baker says the tool works because it uses one of the slickest advertising gimmicks: simplicity. "Those of us in the consumer movement sometimes have a tendency to give people too much information, and then people throw up their hands," Baker explains. "We need to make it bite-sized for people, accessible. That's exactly where the marketing muscle of the plans is. They have absolutely no qualms about simplifying things."

Few state health insurance counseling or aging agencies have the resources of the Medicare Rights Center, however. Most depend on volunteers and lack funding. By Sofaer's estimate, federal funding for the State Health Insurance Programs amounts to a meagre 25 cents per Medicare beneficiary. Without more federal regulation and funding in this area, HMO marketing will surely continue to dominate the beneficiary education process. That is why the University of

Massachusetts Gerontology Institute and Community Catalyst, and many others, have called for standardized information requirements for all Medicare HMOs, improved counseling and education of Medicare beneficiaries, better training for HMO marketing personnel, and stronger federal oversight of HMO marketing practices.

Regulating Managed Care Marketing

Geraldine Dallek, project director at Georgetown University's Institute for Health Care Research and Policy, has advocated stronger regulation of managed care marketing for years. In 1996 testimony before the human services subcommittee of the U.S. Senate Appropriations Committee, Dallek criticized HCFA for failing to impose standards on the industry. And she called for several new standards, including: discontinuing HCFA's Medicare contracts with HMOs that fail to correct documented marketing fraud, standardizing easy-to-read HMO marketing and enrollment information, requiring all HMOs to obtain independent verification for individual Medicare enrollments within three days of enrollment, and prohibiting HMO telemarketing.

In fact, while HMOs have marketed Medicare plans since 1985, HCFA did not issue marketing standards until 1997. That year, it published the "Medicare Managed Care National Marketing Guide," which incorporated some of Dallek's recommendations. Since then, she says, HCFA's oversight has substantially improved. "As recently as the mid-'90s, HCFA did no prior approval of marketing materials," Dallek notes.

"Now the plans have to submit their materials for HCFA review, and they have to meet those marketing standards in order to participate in Medicare."

In addition to model forms for HMOs to use, HCFA's guide includes standards for promotional activities. For example, a health plan may not offer *free* blood pressure screenings at health fairs. That's because HCFA prohibits enrollment inducements costing more than ten dollars; meals, day trips, and other items worth less than ten dollars are okay.

The guide also says that "beneficiaries with disabilities must be considered part of the audience that any marketing strategy is intended to reach."

Further, the guide requires plans to advise consumers that prospective HMO members may want to retain any supplemental Medigap plan they might have. Existing health problems might prevent them from regaining that coverage if they later leave the HMO.

The guide also identifies specific language that health plans "must use, can't use, or can use" for specific items, such as the HMO requirement that members only use providers within the plan's network.

Medicare Rights Center
SUS OPCIONES DE MEDICARE:
Preguntas que Usted Debe Hacerse

Si Ud. NECESITARIA SALUDA O EN EL FUTURO NECE. ATENDIENDO POR MEDICOS ESPECIALISTAS PERO NO PUEDE COSTARSE GASTOS INESPERADOS:
 ¿Quien usar la oportunidad de atenderse con un especialista si así lo desea? Solamente el Medicare tradicional con un "Medigap" o póliza de seguro de atención de la posterioridad de un especialista de su le requiere por muy poco o ningún costo.

Si Ud. NECESITA ATENCIONES MEDICAS CUANDO ESTA DE VIAJE:
 ¿Viaja frecuentemente o por largos periodos del año? Si es así, probablemente encontrará una salud que le proporcione cuando está de viaje. Medicare tradicional provee protección costosa en estas situaciones. Si además tiene un seguro suplementario de Medicare ("Medigap"), esta cobertura también cubre una completa durante su viaje. Si se suscribe en un "HMO," "PPO" es probable que solamente pueda coberturas limitadas al viaje. Un plan "PPO" prohíbe beneficiarios coberturas costosas para su recuperación completa.

Si Ud. TIENE UN SEGURO MEDICO PROPUESTO POR UN EMPLEADOR ANTERIOR O UNO ("PLAN DE RETIRO"):
 ¿Tiene la mayoría del costo de su cuidado médico cubierto en cualquier parte del país? ¿Tiene cobertura sin límite? Si es así, su plan de pensionado le brinda una mayor cobertura cualquier opción de Medicare solo o con una póliza de Medigap, y usted debería pensar detenidamente antes de asociarse a él, porque generalmente no podrá recuperarlo. Dado lo que puede perderlo automáticamente si se sale del Medicare tradicional.

Si Ud. TIENE UN PRESUPUESTO FIJO:
 ¿Tiene muy poco dinero para gastos médicos inesperados? Si es así, debería considerar Medicare tradicional con una póliza de Medigap, o un "HMO" o "PPO" con los costos más bajos y posibles.

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However, all these are standards for the agency's review, not regulations. Nor does HCFA do much to enforce the standards. And while HCFA says it reviews all marketing materials before contracting with HMOs, the agency admits it has no capacity to monitor actual marketing meetings and other sales activities.⁵ Besides, HCFA does seem to have its hands full—with Y2K problems, Medicare fraud, Medicare budget cuts, and Medicare + Choice implementation.

Nevertheless, says Dallek, HCFA must improve its standards. She's particularly concerned about the provision in the 1997 Balanced Budget Act allowing independent insurance agents to sell some of the new varieties of Medicare plans. "What's going to happen if you get these regular insurance agents selling plans?" Dallek asks. "And if they're paid by the referral, by the enrollment? Those guys are not trained."

Baker, at the Medicare Rights Center, agrees. "What the heck do these people know about Medicare?" he asks. "They aren't being supervised by any government entity or by the HMOs. It's the total devolution of responsibility to the point where there is no responsibility."

Dallek says HCFA should require standardized training for all Medicare HMO marketing personnel. It should also require that HMOs tie marketing agents' commissions to the retention of enrollees. And HCFA should at least test the concept of designating a neutral entity, whether itself or another agency, to do Medicare managed care enrollment. None of these suggestions has become HCFA policy.

Given HCFA's failure to police HMO marketing, local action is clearly needed, notes Community Catalyst

policy analyst and organizer Jacquie Anderson. She provided technical assistance to the consumer groups that participated in the Community Catalyst/Gerontology Institute HMO monitoring project.

"HCFA doesn't have the resources it needs to provide effective oversight," Anderson explains. "But local consumers, trained to monitor how HMOs market their plans to Medicare beneficiaries, can make a difference. Gathering data on the marketing activity taking place in your community can help keep local HMOs honest."

Medicare Managed Care Education: Key Pieces, Key Ideas

Fortunately, Medicare + Choice is off to a slow start. HCFA expected to launch it in November 1999, but the agency has received few proposals from insurers or providers. Meanwhile, HCFA has begun its education campaign, which may at least "build some awareness that change is coming," says Craig Schneider, HCFA's Medicare + Choice outreach coordinator for New England.

A year ago, many consumer advocates were in a panic about how to help Medicare beneficiaries sort through new options. Now, with the industry dragging its feet, many say that it makes more sense to focus on the basics, differentiating between traditional and managed Medicare.

"Nobody at this point should be educating people about Medicare + Choice, because the choices don't really exist right now," Dallek says. "It absolutely doesn't make sense. Why get beneficiaries all worked up about plans that aren't even offered today?"

The delay has given researchers time to think about the real information needs of Medicare beneficiaries. Clear information on quality of care under various Medicare plans is not only crucial; it is increasingly available, notes Sofaer, who also leads the Medicare Quality Information Project, with support from The Commonwealth Fund.

That project relies on quality data from all Medicare HMOs, which is based on the Health Plan Employer Data and Information Set developed by the National Committee for Quality Assurance. Sofaer's project is trying to figure out how to present that data in a way that helps consumers make decisions, rather than its current orientation toward clinical medical indicators. Another contributor in this field is the Foundation for Accountability, which is trying to develop consumer-driven, quality-of-care indicators.

As part of their own Consumer Assessment of Health Plans Study, the Agency for Health Care Policy and Research and HCFA are funding a pilot Kansas City effort to give beneficiaries easily understood comparative information to help them select among Medicare plans. Undertaken by the Kansas Foundation for Medical Care, the project has surveyed 2,600 people about their experiences with the area's five Medicare HMOs. The result is a consumer booklet that answers questions like: "Do doctors communicate well with their patients?" and "How would you rate the specialists you have seen?"

Sofaer says consumers also need help in developing their "decision-making framework." That means learning what's at stake, and understanding what she calls the nature of the decision. "In the past, you made

separate decisions about how much a plan cost, did it cover a procedure or not, and which doctor to use,” Sofaer explains. “Now, all that’s integrated in one big decision, which determines everything else.”

Advocates who work directly with Medicare beneficiaries tend to focus on identifying the factors shaping the decision. In Cleveland, the Coalition to Monitor Medicare Managed Care stresses, first of all, that no beneficiary has to change coverage. The coalition advises that “if you like traditional Medicare, you should stick with it.” The coalition has just released its third version of “Making the Decision,” a pamphlet that walks beneficiaries through some of the key questions by focusing on “the three Cs:” cost, choice, and personal circumstances.

In Pennsylvania, Jennifer Morith of the Center for Advocating for the Rights and Interests of the Elderly, stresses five key points:

- Know what coverage you have now. Ask us if you don’t understand it.
- HMO coverage means a network, and seeing a doctor outside it will cost more.
- HMOs must provide the same benefits as traditional Medicare. “If you could get it before, and not now, in your HMO, call us.”
- Under Medicare, you have a right to ask questions and file complaints.
- Look at your Medicare card: on the back, there’s an 800 number to call for help.

The community-based advocates who do this work play a crucial role, says Edelstein, of the Center for Medicare Education. In the swirl of glitzy HMO commercials and crisis-driven news, they serve as “neutral, information intermediaries.” Funded by the Robert Wood Johnson Foundation, the Center for Medicare Educa-

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- Consumer Advocacy in Medicare HMOs* December 1996
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tion will support them by serving as a clearinghouse for proven educational materials. Along with the Medicare Rights Center, it is sponsoring a series of two-day Training Outreach Programs for Medicare educators. Currently, six more sessions are planned, in Tampa, Minneapolis, Denver, Philadelphia, Cleveland, and Portland, Maine.

Monitoring HMO Marketing: A Tool for Consumer Involvement

It is not simply that each Medicare beneficiary's choice of a health plan is at issue. The continuing nature of the Medicare program as a whole is at stake. While the marketing babble is about "choice," Community Catalyst's Villers notes the congressional call for a "defined contribution" or voucher-based Medicare system would guarantee beneficiaries little except the dollar amount of that voucher.

"Choice could be a Trojan horse," Villers adds, "for abandoning the security of the universal, defined *benefit* package that has always been the hallmark of Medicare."

Clearly, for Medicare beneficiaries, the national debate entails decisions both personal and political. Consumer monitoring projects like that jointly undertaken by Community Catalyst and the University of Massachusetts Gerontology Institute can be a crucial tool for beneficiaries and their advocates.

Such efforts can help build capacity for effective political involvement at two levels. First, they provide a technique for analyzing how local Medicare HMOs are marketing to the area's beneficiary population.

Volunteers who pose as regular consumers "mirror" the process that regular consumers shopping for a Medicare plan go through, notes

Karen Quigley, one of the project's principal investigators. "They go through the phone call with a marketing agent, a meeting to find out more, and a look at the paperwork anyone going through the process with that company would get," Quigley explains. Such information lends itself to follow-up with local HMOs. "It positions your organization to say, 'Look, we found these problems. Isn't there a way that you can do this better?'"

Looking to the second level of political involvement, Catalyst policy director Miller adds that addressing Medicare HMO marketing conduct is not an end in itself. "There are a lot of serious policy issues on the horizon with respect to Medicare, and getting consumers involved in policing market conduct is a way to begin building an informal constituency of people prepared to take on these larger issues."

What are some of these fundamental issues? Miller lists several, including the lack of Medicare coverage for prescription drugs and long-term care, the probable segregation of low-income seniors into lower quality plans if the Breaux voucher approach prevails, and the question of whether Medicare's HMO beneficiaries truly receive quality care. The list could go on, says Miller.

In Illinois, Jim Duffett of the Campaign for Better Health Care also has his eye on the policy debate. That's why his organization is conducting a second round of monitoring. Like Miller, Duffett feels that educating and training a cadre of Medicare HMO "monitors" is an investment that will pay off as a political strategy. The seniors who comprised most of the "undercover" volunteers are now prepared to be much more convincing in the policy debate.

"They're pretty damn articulate," Duffett adds, "enough to really go out and talk to their Congressman and to the press." And they will get a chance to do that—Duffett is sure of that.

"This Medicare debate is not going away," Duffett says. "It will be going on hot and heavy for the next two-and-half years, all the way up until the time Al Gore runs—so we've got a couple of years to do some leadership building. This time around, we're really going to be ready."

Resources

"Making the Decision." Available from Coalition to Monitor Medicare Managed Care, Western Reserve Area Agency on Aging, 925 Euclid Avenue, Suite 600, Cleveland, Ohio 44115 (216)621-8010

"Medicare Options Traffic Light." Available from Medicare Rights Center, 1460 Broadway, New York City, New York 10036 (212)869-3850

"Compare York Health Plan Choices: Medicare 1998." Available from Kansas Foundation for Medicare Care (Part of the Consumer Assessment of Health Plans Study, funded by the Agency for Health Care Policy & Research and HCFA)

"Medicare Managed Care National Marketing Guide." 1997. Available from Center for Health Plans and Providers, Health Care Financing Administration, U.S. Department of Health and Human Services

"Monitoring Medicare HMOs: A Manual for Advocates." Available from Community Catalyst, 30 Winter Street, 10th floor, Boston, MA 02108 (617)338-6035

Center for Medicare Education, 60 E. 68th Street, New York City, NY 10028 (212)517-1300

Notes

- ¹ Geraldine Dallek, M.P.H., “Safeguarding Seniors Health Care: Quality in Managed Care,” Testimony before the Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the Committee on Appropriations, U.S. Senate, November 13, 1996; Geraldine Dallek, et al., “Marketing HMOs to Medicare Beneficiaries,” *Health Affairs*, July/August 1998, for the Henry J. Kaiser Family Foundation, Washington, D.C.; “Enhancing Consumer Monitoring of HMO Sales and Marketing Practices,” Gerontology Institute/University of Massachusetts, Boston and Community Catalyst, Boston, 1999; Geraldine Dallek, “Information Poor in the Information Age,” Medicare Rights Center, January 1999; Geraldine Dallek, “Medicare HMO Marketing in the Information Age,” Medicare Rights Center, January 1999; and Robert Pear, “Government Says HMOs Mislead Medicare Recipients,” *New York Times*, April 13, 1999.
- ² “Medicare at a Glance,” Medicare Policy Project, Kaiser Family Foundation, July 1998.
- ³ For a description of the Medicare + Choice options, as well as a comparison of consumer protection provisions, see “Consumer Protections in Medicare + Choice,” prepared for the Henry J. Kaiser Family Foundation by Geraldine Dallek, M.P.H., Institute for Health Care Research and Policy, Georgetown University, December 1998.
- ⁴ Judith Hibbard, et al., “Can Medicare Beneficiaries Make Informed Choices?” *Health Affairs*, November/December 1998.
- ⁵ Pear, “Government Says HMOs Mislead Medicare Recipients.”

Letters from Readers

Excerpted below are two letters that we received in response to our November issue of *States of Health* on conversion foundation philanthropy. Kirke Wilson, president of the Rosenberg Foundation in San Francisco, wrote:

“Because conversion foundations do not have a ‘donor’ in the conventional sense, there is a tendency to treat them as more public than private in nature and responsibility. One manifestation of this is the recurring suggestion that the proceeds of philanthropies should be used exclusively for indigent care or that their governing boards be appointed by elected officials. For much of the past 150 years, foundations in the United States have oscillated between their private origins and their public purposes. The general conclusion has been that these institutions have both a public and a private character. They are public in that they are irrevocably and exclusively dedicated to public purposes and must disclose their activities to the public. At the same time, they are private in their origins and governance.

This balance of public and private may shift over time but it protects the institutions from tipping into excesses of public or private. It guards against becoming a quasi-governmental entity or a private club. It also enables the institution to select, if it chooses, long-term benefits rather than short-term, or attacking the causes rather than the symptoms.

Conversion foundations, because they are often the result of public controversy, are likely to be challenged to be more public and more accountable than other philanthropies. This is healthy and may provide models for all philanthropy as we continue to explore the anomalies of private wealth dedicated to public purposes in a democratic society.”

Steve Viederman, president of the Jessie Smith Noyes Foundation in New York, wrote:

“Investment management has, for too long, been thought of separate from the ‘real’ work of foundations. But... investment management can add real value beyond simply making additional funds available for more grants...”

Shareholder activity can impact corporate behavior in support of the work of grantees and the foundation’s mission. These activities include voting proxies, letter writing and meetings with the management of portfolio companies, as well as filing and co-filing shareholder resolutions. Noyes, for example, was able to get Intel to change its Environmental, Health and Safety policy to include a commitment to share information with communities. We filed the resolution in support of one of our grantees, the SouthWest Organizing Project, and as part of their organizing strategy.

In cooperation with the Interfaith Center on Corporate Responsibility, Noyes has established the Foundation Partnership on Corporate Responsibility (FPCR). FPCR provides assistance to foundations in voting their proxies, and in filing

and co-filing resolution with corporations in a foundation's portfolio. There is no charge for this service, which carries no commitment other than to be informed about how a foundation's portfolio companies are relating to issues of concern to the foundation and its grantees. For information contact Tim Smith, FPCR c/o Interfaith Center On Corporate Responsibility, 475 Riverside Drive – Room 550, New York, NY 10015.

In addition, foundations can screen their portfolios to exclude industries and companies whose products and/or processes are antithetical to the work of the foundation...it might...be important to consider the effect of corporations with particularly poor environmental records that can be related to poor health in the communities in which they are located...

We would be pleased to share our experiences over the last six years. Anyone who is interested should feel free to contact me by phone (212)684-6577, fax (212)689-6549, or e-mail—stevev@noyes.org.



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